

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0042424</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Maple Lawn Health Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>700 N. Main St.</u> <u>Eureka</u> <u>61530</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Woodford</u>		(Signed) _____ (Date) _____																									
<b>Telephone Number:</b> <u>309 467-2337</u> <b>Fax #</b> <u>309 467-9097</u>		(Type or Print Name) <u>Roger W. Hasler</u>																									
<b>IDPA ID Number:</b> <u>370681536001</u>		(Title) <u>Chief Financial Officer</u>																									
<b>Date of Initial License for Current Owners:</b> <u>1922</u>		(Signed) <u>See Accountants' Compilation Report</u> (Date) _____																									
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		(Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax # ( )	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>IRS Exemption Code</b> <u>501(c)3</u>		<b>Paid Preparer</b>																									
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Roger Hasler</u> <b>Telephone Number:</b> <u>(309) 467-2337</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center# 0042424 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>89</u>	Skilled (SNF)	<u>89</u>	<u>32,485</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,585</u>	5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,517</u>	<u>6,709</u>	<u>1,568</u>	<u>13,794</u>	8
9	SNF/PED					9
10	ICF	<u>6,196</u>	<u>10,571</u>	<u>0</u>	<u>16,767</u>	10
11	ICF/DD					11
12	SC	<u>1,111</u>	<u>8,740</u>	<u>0</u>	<u>9,851</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,824</u>	<u>26,020</u>	<u>1,568</u>	<u>40,412</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 93.83%

D. How many bed-hold days during this year were paid by Public Aid?

103 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/1922

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date                      NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 13 and days of care provided 1,568Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning:

01/01/03

Ending:

12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	274,234	16,608	15,102	305,944		305,944	(784)	305,160		1
2	Food Purchase		286,807		286,807		286,807	(71,921)	214,886		2
3	Housekeeping	157,426	28,857	3,532	189,815		189,815	(174)	189,641		3
4	Laundry	60,440	11,255	664	72,359		72,359		72,359		4
5	Heat and Other Utilities			138,358	138,358		138,358	(130)	138,228		5
6	Maintenance	50,364	7,304	115,986	173,654		173,654	(65,488)	108,166		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	542,464	350,831	273,642	1,166,937		1,166,937	(138,497)	1,028,440		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	1,790,646	132,569	150,907	2,074,122		2,074,122		2,074,122		10
10a	Therapy			167,102	167,102		167,102		167,102		10a
11	Activities	102,276	7,808	7,066	117,150		117,150		117,150		11
12	Social Services	50,561	1,116	648	52,325		52,325		52,325		12
13	Nurse Aide Training			450	450		450		450		13
14	Program Transportation			925	925		925		925		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,943,483	141,493	328,898	2,413,874		2,413,874		2,413,874		16
	<b>C. General Administration</b>										
17	Administrative	81,738		75,604	157,342		157,342	(141,814)	15,528		17
18	Directors Fees										18
19	Professional Services			21,435	21,435		21,435	3,577	25,012		19
20	Dues, Fees, Subscriptions & Promotions			44,273	44,273		44,273	1,815	46,088		20
21	Clerical & General Office Expenses	337,898	99	43,035	381,032		381,032	33,069	414,101		21
22	Employee Benefits & Payroll Taxes			628,788	628,788		628,788	105,944	734,732		22
23	Inservice Training & Education			6,399	6,399		6,399		6,399		23
24	Travel and Seminar			7,185	7,185		7,185	3,605	10,790		24
25	Other Admin. Staff Transportation			133	133		133	3,440	3,573		25
26	Insurance-Prop.Liab.Malpractice			99,229	99,229		99,229	7,225	106,454		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	419,636	99	926,081	1,345,816		1,345,816	16,861	1,362,677		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,905,583	492,423	1,528,621	4,926,627		4,926,627	(121,636)	4,804,991		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maple Lawn Health Center

#0042424

Report Period Beginning: 01/01/03 Ending: 12/31/03

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			162,868	162,868		162,868	48,642	211,510			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,758	77,758		77,758	(21,501)	56,257			32
33	Real Estate Taxes			2,700	2,700		2,700	(2,700)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			243,326	243,326		243,326	24,441	267,767			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,431	313	29,744		29,744		29,744			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728		48,728		48,728			42
43	Other (specify):*			105,275	105,275		105,275	(105,275)				43
44	<b>TOTAL Special Cost Centers</b>		29,431	154,316	183,747		183,747	(105,275)	78,472			44
45	<b>GRAND TOTAL COST</b>											
	(sum of lines 29, 37 & 44)	2,905,583	521,854	1,926,263	5,353,700		5,353,700	(202,470)	5,151,230			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(71,921)	2		4
5 Telephone, TV & Radio in Resident Rooms	(10,323)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(174)	3		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest	(23,151)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(1,983)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(3,961)	43		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule see schedule 5A	(104,362)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,875)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	13,405		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 13,405		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (202,470)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

## Maple Lawn Health Center

ID# 0042424

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Machine Offset	\$ (784)	1	1
2	Real Estate Taxes	(5,172)	33	2
3	Flowers	(1,040)	43	3
4	Miscellaneous Income Offset	(81)	21	4
5	Management Fee (MLH)	(65,858)	43	5
6	Out of State Travel	0	24	6
7	Non Operating Expenses	(25)	43	7
8	Telephone	(6,600)	21	8
9	Non Allowable Dues	(734)	20	9
10	Laboratory	(4,710)	43	10
11	Radiology	(1,777)	43	11
12	Investment Market Adjustment	(17,268)	43	12
13	Professional Services	0	43	13
14	Miscellaneous non-allowable expenses	(313)	43	14
15				15
16				16
17				17
18				18
19				19
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24				24
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47				47
48				48
49	Total Page 5A	(104,362)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(784)	0	0	0	0	0	0	0	0	0	0	(784)	1
2	Food Purchase	(71,921)	0	0	0	0	0	0	0	0	0	0	(71,921)	2
3	Housekeeping	(174)	0	0	0	0	0	0	0	0	0	0	(174)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	(130)	0	0	0	0	0	0	0	0	0	(130)	5
6	Maintenance	0	(65,488)	0	0	0	0	0	0	0	0	0	(65,488)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(72,879)</b>	<b>(65,618)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(138,497)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(141,814)	0	0	0	0	0	0	0	0	0	(141,814)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,983)	5,560	0	0	0	0	0	0	0	0	0	3,577	19
20	Fees, Subscriptions & Promotions	(734)	2,549	0	0	0	0	0	0	0	0	0	1,815	20
21	Clerical & General Office Expenses	(6,681)	39,750	0	0	0	0	0	0	0	0	0	33,069	21
22	Employee Benefits & Payroll Taxes	0	105,944	0	0	0	0	0	0	0	0	0	105,944	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,605	0	0	0	0	0	0	0	0	0	3,605	24
25	Other Admin. Staff Transportation	0	3,440	0	0	0	0	0	0	0	0	0	3,440	25
26	Insurance-Prop.Liab.Malpractice	0	7,225	0	0	0	0	0	0	0	0	0	7,225	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(9,398)</b>	<b>26,259</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16,861</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(82,277)</b>	<b>(39,359)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(121,636)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	48,642	0	0	0	0	0	0	0	0	0	48,642	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,151)	1,650	0	0	0	0	0	0	0	0	0	(21,501)	32
33	Real Estate Taxes	(5,172)	2,472	0	0	0	0	0	0	0	0	0	(2,700)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(28,323)</b>	<b>52,764</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>24,441</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(105,275)	0	0	0	0	0	0	0	0	0	0	(105,275)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(105,275)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(105,275)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(215,875)</b>	<b>13,405</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(202,470)</b>	<b>45</b>

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Maple Lawn Health Center, Inc	100			Maple Lawn Homes	Eureka	Ret House Mgmt
				Maple Lawn Apart	Eureka	Ret. Housing
				Maple Lawn Cottage	Eureka	Ret. Housing
				Maple Lawn Total		
				Living Care	Eureka	Home Care

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$ 7,781	Maple Lawn Homes	0.00%	\$ 7,651	\$ (130)	1
2	V	6 Maintenance Expense	70,733	Maple Lawn Homes	0.00%	5,245	(65,488)	2
3	V	17 Administrative Service Fees	141,814	Maple Lawn Homes	0.00%		(141,814)	3
4	V	19 Professional Fees		Maple Lawn Homes	0.00%	5,560	5,560	4
5	V	20 Fees, Subscriptions, & Promotions		Maple Lawn Homes	0.00%	2,549	2,549	5
6	V	21 Clerical & General Office		Maple Lawn Homes	0.00%	39,750	39,750	6
7	V	22 Employee Benefits		Maple Lawn Homes	0.00%	105,944	105,944	7
8	V	24 Travel Seminar		Maple Lawn Homes	0.00%	3,605	3,605	8
9	V	25 Other Admin. Staff Trans		Maple Lawn Homes	0.00%	3,440	3,440	9
10	V	26 Insurance - Prop Liab		Maple Lawn Homes	0.00%	7,225	7,225	10
11	V	30 Depreciation		Maple Lawn Homes	0.00%	48,642	48,642	11
12	V	32 Interest		Maple Lawn Homes	0.00%	1,650	1,650	12
13	V	33 Real Estate Taxes		Maple Lawn Homes	0.00%	2,472	2,472	13
14	Total		\$ 220,328			\$ 233,733	\$ *	13,405 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Maple Lawn Homes

Street Address

700 North Main

City / State / Zip Code

Eureka, IL 61530

Phone Number

( 309 ) 467-2337

Fax Number

( 309 ) 467-9097

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	6,948,731	8	\$ 11,332	\$ 4,691,826	\$ 7,651	1
2	6	Maintenance Expense	Time Study	17,463	8	27,666	3,311	5,245	2
3	19	Professional Service	Accumulated Cost	6,948,731	8	7,663	4,691,826	5,174	3
4	19	Professional Service	Salary Allocation	742,820	8	852	336,943	386	4
5	20	Fees, Subscriptions, & Prom	Accumulated Cost	6,948,731	8	3,743	4,691,826	2,527	5
6	20	Fees, Subscriptions, & Prom	Salary Allocation	742,820	8	49	336,943	22	6
7	21	Clerical, General Office Exp.	Accumulated Cost	6,948,731	8	58,760	4,691,826	39,675	7
8	21	Clerical, General Office Exp.	Time Study	17,463	8	393	3,311	75	8
9	22	Employee Benefits	Accumulated Cost	6,948,731	8	2,878	4,691,826	1,943	9
10	22	Employee Benefits	Salary Allocation	742,820	8	229,280	336,943	104,001	10
11	24	Travel & Seminar	Accumulated Cost	6,948,731	8	5,339	4,691,826	3,605	11
12	25	Other Admin. Staff Trans	Accumulated Cost	6,948,731	8	5,094	4,691,826	3,440	12
13	26	Insurance - Prop. Liab.	Accumulated Cost	6,948,731	8	10,701	4,691,826	7,225	13
14	30	Depreciation	Accumulated Cost	6,948,731	8	72,040	4,691,826	48,642	14
15	32	Interest	Accumulated Cost	6,948,731	8	2,444	4,691,826	1,650	15
16	33	Real Estate	Accumulated Cost	6,948,731	8	3,661	4,691,826	2,472	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 441,895	\$	\$ 233,733	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/03

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12/31/03

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	FHA Mortgage # 1		X	Building	\$4,663.00	4/4/79	\$	860,000	\$	321,160	4/4/11	0.0500	\$	16,810	1				
2	FHA Mortgage # 2		X	Building	\$6,300.00	7/7/89		900,000		575,924	7/7/14	0.0650		38,585	2				
3	FHA Mortgage # 3		X	Building	\$665.00	7/7/89		90,000		58,996	7/7/14	0.0713		4,328	3				
4	City of Eureka Bonds		X	Building	\$3,465.00	7/7/89		455,000		280,641	7/7/12	0.0765		17,482	4				
5	Heartland		X	Line of credit	varies	02/26/03		80,000		0	02/26/04	0.0400		553	5				
	Working Capital																		
6															6				
7															7				
8															8				
9	TOTAL Facility Related				\$15,093.00		\$	2,385,000	\$	1,236,721				\$	77,758	9			
	B. Non-Facility Related*																		
10	Interest Income Offset													(23,151)	10				
11	Allocated from Management Company													1,650	11				
12															12				
13															13				
14	TOTAL Non-Facility Related						\$		\$				\$	(21,501)	14				
15	TOTALS (line 9+line14)						\$	2,385,000	\$	1,236,721				\$	56,257	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Maple Lawn Health Center**# **0042424** Report Period Beginning:**01/01/03** Ending:**12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		\$	<b>2,700</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>2,589</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(111)</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	<b>Allocation from Management Co.</b>	\$	<b>2,472</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	<b>Nonexempt Real Estate Taxes</b>		<b>5,061</b>	
<b>TOTAL REFUND \$ For Tax Year (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>0</b>	7

  

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	<b>2,534</b>	8
	1999	<b>2,442</b>	9
	2000	<b>2,473</b>	10
	2001	<b>2,566</b>	11
	2002	<b>2,589</b>	12

  

	<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

  

<b>2002 Real Estate Tax Bill</b>	<b>2566</b>	<b>* While this entity is a 501(3) not for profit organization,</b>
<b>Est. Increase</b>	<b>220</b>	<b>it is paying real estate taxes for a portion of the facility</b>
<b>Est. 2003 Tax</b>	<b>2811</b>	<b>that is deemed nonexempt.</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Maple Lawn Health Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0042424

CONTACT PERSON REGARDING THIS REPORT Mr. Roger Hasler

TELEPHONE 309 467-2337 FAX #: 309 467-9097

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>13-12-201-026</u>	<u>Beauty Shop</u>	<u>\$ 2,589.04</u>	<u>\$ None</u>
2.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
3.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
4.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
5.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
6.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
7.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
8.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
9.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
10.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
		<b>TOTALS</b>	<b>\$ <u>2,589.04</u></b>	<b>\$ <u>None</u></b>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?            YES       X       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

42,837

B. General Construction Type:

Exterior

Brick

Frame

Brick, Mortar, Steel

Number of Stories

2

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Maple Lawn Homes - Retirement Housing Management

Maple Lawn Apartments - Retirement Housing 100 Apartments

Maple Lawn Cottages - Retirement Housing 102 Cottages

Maple Lawn Total Living Care - Home Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Health Center	85,000	1965	\$ 1,386	1
2	Health Center	39,000	1969	1,000	2
3	TOTALS	124,000		\$ 2,386	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Maple Lawn Health Center

# 0042424

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	80	1965	1965	\$ 472,000	\$ 7,867	60	\$ 7,867	\$	\$ 306,145
5		1974	1974	20,378	408	50	408		11,975
6		1980	1980	750,017	16,667	45	16,667		398,282
7		1982	1982	7,703		20			7,703
8	38	1989	1989	1,459,363	32,430	45	32,430		470,239
9	Improvement Type**								
10	7 Landscaping - disposed of 2002	1982			1,155	20	1,155		
11	8 Trees	1984		1,125	56	20	56		1,107
12	9 Trees	1984		1,976	99	20	99		1,919
13	15 Landscaping - Front of HC	1992		1,100		10			1,100
14	16 Asphalt Repair	1993		4,058	372	10	372		4,058
15	17 Parking Lot Lighting	1995		1,282	128	10	128		1,089
16	18 Asphalt Parking Lot	1995		2,528	253	10	253		2,106
17	19 ADU Enclosure	1995		4,305	431	10	431		3,552
18	20 Parking Blocks (20)	1996		654	65	10	65		464
19	285 Lower Level Renovation	1981		203,080	8,830	23	8,830		194,986
20	286 Lower Level Renovation	1982		35,963	1,635	22	1,635		35,019
21	287 Fixture Repairs & Refinish	1983		9,750		10			9,750
22	288 Trellis	1983		1,063		10			1,063
23	11 Loading Dock	1985		1,642	82	20	82		1,525
24	292 Deck	1992		2,574		10			2,574
25	293 Room Renovation	1992		1,067		10			1,067
26	294 Lobby Renovation	1993		32,583	1,086	10	1,086		32,583
27	295 Central Supply Room	1993		1,697	127	10	127		1,697
28	296 ADU Cabinets	1994		1,365	114	12	114		1,109
29	297 Wallpaper	1994		776		8			776
30	28 Wallpaper	1995		1,181	25	8	25		1,181
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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**\*\*Improvement type must be detailed in order for the cost report to be considered complete**

## STATE OF ILLINOIS

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Facility Name &amp; ID Number    Maple Lawn Health Center

#    0042424

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## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,141,859	\$ 76,211		\$ 76,211		\$ 1,604,625	1
2	330 Wander Guard Door Monitor	1993	1,212		8			1,212	2
3	331 MTCO Telephone System	1993	12,883	1,074	10	1,074		12,883	3
4	62 Paging System	1994	707		3			707	4
5	63 ADU Door Monitoring System	1994	914		3			914	5
6	64 Upgrade Elevator - Disposed of in 2002	1994							6
7	65 Air Conditioning -Dining Room	1994	1,723	86	20	86		804	7
8	68 Hatco Toaster	1995	980	98	10	98		866	8
9	69 Fiber Optics Wiring	1995	4,645		5			4,645	9
10	70 Dining Room A/C Unit	1995	3,187	159	20	159		1,381	10
11	71 Wood Graphics Signs	1995	1,131		7			1,131	11
12	73 Kitchen Shelves / Counter	1995	6,667	444	15	444		3,652	12
13	74 Parker Bath	1995	8,598	860	10	860		6,950	13
14	75 Magnetic Door Lock System	1996	2,846	285	10	285		2,229	14
15	76 Service Sink	1996	656	66	10	66		514	15
16	77 Nurse Call System	1996	21,777	2,178	10	2,178		15,425	16
17	78 A/C Unit -Central Supply Room	1996	3,515	352	10	352		2,695	17
18	79 Elevator Upgrade	1996	13,117	1,312	10	1,312		10,056	18
19	80 A/C Unit Laundry Room	1996	5,986	599	10	599		4,590	19
20	81 A/C Unit Kitchen	1996	5,688	569	10	569		4,313	20
21	82 Alarm System	1996	709	89	8	89		650	21
22	84 Tektone Door Alarm	1996	673	84	8	84		596	22
23	405 Vertical Blinds	1994	1,021		8			1,021	23
24	21 Landscaping	1997	3,116	312	10	312		2,077	24
25	22 Remodel Smoking Area	1997	553	55	10	55		373	25
26	38 Patient Room Renovation	1997	979	122	8	122		816	26
27	39 Lobby Renovation	1997	499	55	9	55		383	27
28	40 Sink & Counter for Empl.Lounge	1997	1,319	165	8	165		1,126	28
29	41 Fireplace Conversion	1997	2,762	276	10	276		1,841	29
30	42 Kitchen Waterline Replacement	1997	1,591	159	10	159		981	30
31	43 Chapel Renovation	1997	17,045	1,705	10	1,705		10,227	31
32	85 Nurse Call System Cords	1997	588		5			588	32
33	86 Addressable Fire alarm System	1997	11,790	1,179	10	1,179		8,155	33
34	TOTAL (lines 1 thru 33)		\$ 3,280,736	\$ 88,494		\$ 88,494		\$ 1,708,426	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,280,736	\$ 88,494		\$ 88,494		\$ 1,708,426	1
2	87 Fire Alarm Annunciator	1997	985	99	10	99		657	2
3	88 Expansion Tank	1997	3,800	475	8	475		3,167	3
4	89 Door Security Upgrade	1997	2,843	284	10	284		1,895	4
5	90 Phone System Additions	1997	821	82	10	82		493	5
6	91 Bathtub	1997	6,080	608	10	608		3,648	6
7	92 Bath Lift	1997	3,294	329	10	329		1,976	7
8	23 Parking Lot Repair	1998	1,829	183	10	183		945	8
9	24 Landscaping	1998	700	70	10	70		379	9
10	44 Boiler Repairs	1998	2,415	242	10	242		1,429	10
11	45 Automatic Door	1998	3,651	365	10	365		2,069	11
12	46 Wing 3 Renovation	1998	2,825	283	10	283		1,460	12
13	47 Dining Room Renovation - disposed of 2003	1998		911	10	911			13
14	93 Hall 3 Fire Detectors	1998	1,794	224	8	224		1,289	14
15	94 Hall 2 Fire Detectors	1998	2,994	374	8	374		2,121	15
16	95 Emergency Generator Repairs	1998	1,356	136	10	136		757	16
17	96 Free Standing Bath	1998	8,958	896	10	896		4,778	17
18	97 Security System/ADU Outdoor Gate	1998	1,127	141	8	141		728	18
19	98 Cable System	1998	24,353	4,871	5	4,871		24,353	19
20	99 A/C Lower Lobby - Bv Dining Rm	1998	3,604	360	10	360		1,802	20
21	25 Asphalt Repair	1999	2,467	247	10	247		1,069	21
22	48 Dining Room Renovation	1999	1,428	143	10	143		679	22
23	49 Hall 6 Renovation	1999	2,588	259	10	259		1,121	23
24	50 New Door for Entrance	1999	2,665	267	10	267		1,110	24
25	51 Hall 7 Renovation	1999	6,647	665	10	665		2,714	25
26	52 Bath Flooring	1999	2,018	252	8	252		1,030	26
27	53 Janitor Floor	1999	326	41	8	41		166	27
28	54 Hall 1 Renovation	1999	2,276	285	8	285		1,162	28
29	55 Electronic Eye Door-Main Entrance	1999	3,723	372	10	372		1,489	29
30	56 Office Renovation	1999	2,458	246	10	246		983	30
31	57 Lounge Renovation	1999	927	93	10	93		371	31
32	100 Door alarms Halls 1 & 3	1999	4,285	536	8	536		2,678	32
33	101 Fire Alarms Halls 1,6,7	1999	5,290	661	8	661		3,141	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,391,263	\$ 103,494		\$ 103,494		\$ 1,780,085	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

## STATE OF ILLINOIS

Page 12D

Facility Name &amp; ID Number    Maple Lawn Health Center

#    0042424

Report Period Beginning:

01/01/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,391,263	\$ 103,494		\$ 103,494	\$	\$ 1,780,085	1
2	102 A/C Condensor	1999	1,001	100	10	100		451	2
3	103 Adjustable Sink	1999	2,569	321	8	321		1,285	3
4	104 Carousel Whirlpool	1999	16,897	1,690	10	1,690		6,759	4
5	105 Heating A/C Unit Hall 6	1999	998	100	10	100		399	5
6	26 Asphalt Repair	2000	2,352	235	10	235		764	6
7	58 Tempered Water System Redesigned	2000	14,400	720	20	720		2,640	7
8	59 Renovate Social Service Office	2000	3,422	342	10	342		1,226	8
9	106/107 Wanderguard Monitors	2000	2,591	324	8	324		1,201	9
10	108 New Boiler in Cleveland Steamer	2000	4,076	408	10	408		1,325	10
11	109 Octel 100 Voicemail System-Disposed of 2003	2000		731	5	731			11
12	110 Cable System Expansion	2000	1,844	369	5	369		1,137	12
13	27 Land Improve- Sidewalk Replacement	2001	485	48	10	48		101	13
14	60 Water System Installation	2001	41,500	2,075	20	2,075		6,052	14
15	61 Administrative Office - Carpet	2001	1,447	181	8	181		497	15
16	111 Fire Alarms- Halls 4 & 5	2001	6,436	805	8	805		2,414	16
17	112 Air Condition Unit Hall 6	2001	3,424	342	10	342		885	17
18	113 Door Alarms - Hall 7	2001	2,757	345	8	345		775	18
19	422 Elevator Safety Edges	2002	3,245	325	10	325		514	19
20	423 Reshingle - Memorial Hall	2002	739	37	20	37		49	20
21	424 A/C Condensor - HC Lobby	2002	785	79	10	79		111	21
22	425 Cable System Upgrade	2002	1,138	228	5	228		304	22
23	443 Sandblasted Redwood Signs	2002	736	105	7	105		114	23
24	447 Room 601 Construction	2003	34,315	1,144	20	1,144		1,144	24
25	448 Room 306 Bathroom Conversion	2003	21,425	1,428	10	1,428		1,428	25
26	449 PT Room Divider Curtain	2003	2,589	173	10	173		173	26
27	450 Crosslink II Traverline Carpet	2003	936	78	8	78		78	27
28	446 Insinkerator Disposer for Kitchen	2003	1,048	140	5	140		140	28
29	458 New Exit Doors & Keypads	2003	9,618	458	7	458		458	29
30	455 New Parking Lot	2003	9,378	456	12	456		456	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,583,414	\$ 117,281		\$ 117,281	\$	\$ 1,812,965	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 325,958	\$ 41,839	\$ 41,839	\$	Various	\$ 199,918	71
72	Current Year Purchases	41,745	2,067	2,067		Various	2,067	72
73	Fully Depreciated Assets	110,714					110,714	73
74	Allocation from Management Company			38,500	38,500			74
75	TOTALS	\$ 478,417	\$ 43,906	\$ 82,406	\$ 38,500		\$ 312,699	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,088,579	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,388	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 211,510	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,122	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,126,865	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Work in Progress	\$ 175,000	92
93			93
94			94
95		\$ 175,000	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>N/A</u>		\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy:

☐

YES

☒

NO

Terms: N/A

\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO

16. Rental Amount for movable equipment: \$ N/A

Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12.                      /2004 \$                     

13.                      /2005 \$                     

14.                      /2006 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>80</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER AIDE <u>40</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 400	\$	\$ 400
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		\$ 50		50
9	TOTALS	\$	\$ 450	\$	\$ 450
10	SUM OF line 9, col. 1 and 2 (e)	\$	450		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ N/A

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	<u>1</u>
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number	Maple Lawn Health Center	#	0042424	Report Period Beginning:	01/01/03	Ending:	12/31/03
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**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS**

Tuition: Apostolic Christian Home

Melissa Jackson	400
	<u>400</u>

Books:

	<u>0</u>
--	----------

Testing:

Melissa Jackson	50
	<u>50</u>

<b>TOTAL EXPENSES</b>	<b><u>450</u></b>
-----------------------	-------------------

SEE ACCOUNTANTS' COMPILATION REPORT

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	1,040	\$ 52,911	\$	1,040	\$ 52,911	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		279	19,469		279	19,469	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C2,3	hrs		1,303	71,337		1,303	71,337	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				30,461		30,461	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	2,622	\$ 143,717	\$ 30,461	2,622	\$ 174,178	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 273,567	\$ 273,567	1
2	Cash-Patient Deposits	11,968	11,968	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 26,972 )	248,759	248,759	3
4	Supply Inventory (priced at cost )	22,251	22,251	4
5	Short-Term Investments			5
6	Prepaid Insurance	283	283	6
7	Other Prepaid Expenses	10,811	10,811	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	19,944	19,944	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 587,583	\$ 587,583	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	325,157	325,157	12
13	Land	2,386	2,386	13
14	Buildings, at Historical Cost	3,607,776	3,607,776	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	500,956	500,956	16
17	Accumulated Depreciation (book methods)	(2,140,435)	(2,140,435)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Work in progress	175,000	175,000	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,470,840	\$ 2,470,840	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,058,423	\$ 3,058,423	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 134,279	\$ 134,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,968	11,968	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,437	119,437	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,135	8,135	31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,811	2,811	32
33	Accrued Interest Payable	5,886	5,886	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	18,909	18,909	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 301,425	\$ 301,425	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,236,721	1,236,721	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,236,721	\$ 1,236,721	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,538,146	\$ 1,538,146	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,520,277	\$ 1,520,277	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,058,423	\$ 3,058,423	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Facility Name            Maple Lawn Health Center  
Provider #                0042424  
Period Ending            12/31/2003

Page 17A

**Schedule 17A**

**XV. Balance Sheet**

**A. Current Assets - Line 9: Other (specify):**

Interest Receivable	785.00
Service Division	(934.00)
Apartments	14.00
Forwarding Acts Intercom	20,440.00
Transportation	(361.00)
<hr/>	
<b>Total</b>	<b>19,944.00</b>

**A. Current Liabilities - Line 36: Other Current Liabilities (specify):**

Uniform Deductions	(208.00)
Section 125 Dental Insurance	0.00
Wage Garnishment Deduction	0.00
Pharmacy Withholding	0.00
Long Term Care Insurance	0.00
Section 125 Life Insurance	1.00
Section 125 Colonial Insurance	0.00
Section 125 - Travelers Cancer Insurance	0.00
Annuity 403(b) plan	19,117.00
<hr/>	
<b>Total</b>	<b>18,910.00</b>

**See Accountants' Compilation Report**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,625,231	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,625,231	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(104,960)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (104,960)	17
	<b>B. Transfers (Itemize):</b>		
18	Rounding	6	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 6	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,520,277	24

\*

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,698,674	1
2	Discounts and Allowances for all Levels	(1,078,695)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,619,979	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,912	6
7	Oxygen	25,697	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 354,609	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,297	13
14	Non-Patient Meals	71,921	14
15	Telephone, Television and Radio	13,868	15
16	Rental of Facility Space		16
17	Sale of Drugs	29,431	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,710	19
20	Radiology and X-Ray	1,124	20
21	Other Medical Services	119,353	21
22	Laundry	174	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 244,878	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	50,482	24
25	Interest and Other Investment Income***	23,151	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 73,633	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	(44,359)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (44,359)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,248,740	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,166,937	31
32	Health Care	2,413,874	32
33	General Administration	1,345,816	33
<b>B. Capital Expense</b>			
34	Ownership	243,326	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	135,019	35
36	Provider Participation Fee	48,728	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,353,700	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(104,960)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (104,960)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name            Maple Lawn Health Center  
Provider #                0042424  
Period Ending            12/31/2003

Page 19A

**Schedule 19A**

**XVII. Income Statement**

**E. Other Revenue**

Description	Amount
Equipment Rental - PP	4,965.00
Equipment Rental - IPA	3,810.00
Vending Machine	784.00
Admission Fee	7,250.00
Loss on Sale of Fixed Asset	(61,249.00)
Miscellaneous	81.00
<b>Total</b>	<b>(44,359.00)</b>

**See Accountants' Compilation Report**

Facility Name & ID Number **Maple Lawn Health Center**# **0042424**Report Period Beginning: **01/01/03**Ending: **12/31/03**

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,276	\$ 54,743	\$ 24.05	1
2	Assistant Director of Nursing	1,904	2,160	45,200	20.93	2
3	Registered Nurses	12,175	13,192	267,953	20.31	3
4	Licensed Practical Nurses	16,281	17,643	295,535	16.75	4
5	Nurse Aides & Orderlies	83,922	90,573	1,039,135	11.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,594	4,116	48,412	11.76	8
9	Activity Director	1,936	2,176	29,681	13.64	9
10	Activity Assistants	4,694	5,143	45,184	8.79	10
11	Social Service Workers	4,323	4,854	50,561	10.42	11
12	Dietician	1,392	1,508	16,378	10.86	12
13	Food Service Supervisor	1,984	2,112	33,062	15.65	13
14	Head Cook	9,707	11,078	106,681	9.63	14
15	Cook Helpers/Assistants	13,781	15,003	118,113	7.87	15
16	Dishwashers					16
17	Maintenance Workers	3,566	4,067	50,363	12.38	17
18	Housekeepers	13,525	15,012	157,426	10.49	18
19	Laundry	6,891	7,449	60,440	8.11	19
20	Administrator	2,021	2,284	81,738	35.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,113	6,757	78,359	11.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care <a href="#">See Schedule 20A</a>			67,080		32
33	Other(specify) <a href="#">See Schedule 20A</a>			259,539		33
34	TOTAL (lines 1 - 33)	189,833	207,403	\$ 2,905,583 *	\$ 14.01	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	306	\$ 8,552	L1, C3	35
36	Medical Director	Monthly	1,800	L9, C3	36
37	Medical Records Consultant	Monthly	2,160	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	243	15,795	L10A, C3	40
41	Occupational Therapy Consultant	243	14,580	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	710	L11, C3	44
45	Social Service Consultant	15	608	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	824	\$ 46,005		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	118	\$ 4,315	L10, C3	50
51	Licensed Practical Nurses	813	26,950	L10, C3	51
52	Nurse Aides	3,299	57,352	L10, C3	52
53	TOTAL (lines 50 - 52)	4,230	\$ 88,617		53

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 20A

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Nurse Secretary	2155	2301	27117	11.78	10
Unit Ward Clerk	1356	1567	12552	8.01	10
Chaplain			27411		11
<b>Total Line 32 - Other Health Ca</b>	<b>3511</b>	<b>3868</b>	<b>67080</b>	<b>19.79</b>	

Human Resources			40664		21
Accounting & Other Admin			195298		21
Volunteer Coordinator			23577		21
<b>Total Line 33 - Other</b>	<b>0</b>	<b>0</b>	<b>259539</b>	<b>0</b>	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maple Lawn Health Center**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

# 0042424

Report Period Beginning: 01/01/03

Page 21

Ending: 12/31/03

<b>A. Administrative Salaries</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 45%;">Amount</th> </tr> <tr> <td>Steve Evans</td> <td>Administrator</td> <td>0</td> <td style="text-align: right;">\$ 18,791</td> </tr> <tr> <td>Roger W. Hasler</td> <td>Administrator</td> <td>0</td> <td style="text-align: right;">62,947</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 81,738</td> </tr> </table>				Name	Function	Ownership %	Amount	Steve Evans	Administrator	0	\$ 18,791	Roger W. Hasler	Administrator	0	62,947																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,738	<b>D. Employee Benefits and Payroll Taxes</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> <tr><td>Workers' Compensation Insurance</td><td style="text-align: right;">\$ 102,534</td></tr> <tr><td>Unemployment Compensation Insurance</td><td style="text-align: right;">14,818</td></tr> <tr><td>FICA Taxes</td><td style="text-align: right;">190,564</td></tr> <tr><td>Employee Health Insurance</td><td style="text-align: right;">243,118</td></tr> <tr><td>Employee Meals</td><td> </td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Employee Physical</td><td style="text-align: right;">2,281</td></tr> <tr><td>Annuity Plan 403B</td><td style="text-align: right;">48,920</td></tr> <tr><td>Sick Pay</td><td style="text-align: right;">4,328</td></tr> <tr><td>Group Life Insurance</td><td style="text-align: right;">7,562</td></tr> <tr><td>Employee Appreciation</td><td style="text-align: right;">7,969</td></tr> <tr><td>Allocation from Management Company</td><td style="text-align: right;">105,944</td></tr> <tr><td>Other Employee Benefits</td><td style="text-align: right;">6,694</td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td style="text-align: right;">\$ 734,732</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 102,534	Unemployment Compensation Insurance	14,818	FICA Taxes	190,564	Employee Health Insurance	243,118	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Employee Physical	2,281	Annuity Plan 403B	48,920	Sick Pay	4,328	Group Life Insurance	7,562	Employee Appreciation	7,969	Allocation from Management Company	105,944	Other Employee Benefits	6,694	TOTAL (agree to Schedule V, line 22, col.8)	\$ 734,732	<b>F. Dues, Fees, Subscriptions and Promotions</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> <tr><td>IDPH License Fee</td><td style="text-align: right;">\$ 235</td></tr> <tr><td>Advertising: Employee Recruitment</td><td style="text-align: right;">26,722</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed <u>122</u>)</td><td style="text-align: right;">854</td></tr> <tr><td>Miscellaneous Subscriptions</td><td style="text-align: right;">257</td></tr> <tr><td>Life Service Network</td><td style="text-align: right;">5,298</td></tr> <tr><td>Mennonite Health Services</td><td style="text-align: right;">10,319</td></tr> <tr><td>Miscellaneous Dues</td><td style="text-align: right;">588</td></tr> <tr><td>Allocation from Management Company</td><td style="text-align: right;">1,815</td></tr> <tr><td>Less: Public Relations Expense</td><td style="text-align: right;">( )</td></tr> <tr><td>Non-allowable advertising</td><td style="text-align: right;">( )</td></tr> <tr><td>Yellow page advertising</td><td style="text-align: right;">( )</td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td style="text-align: right;">\$ 46,088</td> </tr> </table>				Description	Amount	IDPH License Fee	\$ 235	Advertising: Employee Recruitment	26,722	Health Care Worker Background Check (Indicate # of checks performed <u>122</u> )	854	Miscellaneous Subscriptions	257	Life Service Network	5,298	Mennonite Health Services	10,319	Miscellaneous Dues	588	Allocation from Management Company	1,815	Less: Public Relations Expense	( )	Non-allowable advertising	( )	Yellow page advertising	( )	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 46,088
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\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center

STATE OF ILLINOIS

# 0042424

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. Life Services Network \$5,298
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,236 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 48,728  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 71,921
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 10  
d. Have vehicle usage logs been maintained? Adequate Records are Maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: Heinold-Banwart, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.